Print Reset

(Personal Service) (Mailed)

VOLUNTARY PAYMENT FORM

Michigan Department of Labor & Economic Growth
Workers' Compensation Agency/Board of Magistrates
P.O. Box 30016, Lansing, MI 48909

_____ Day of _____ 20____

_____
Magistrate/Mediator (Please print)

Plaintiff	Defendant
Plaintiff's Social Security Number	Date of Injury

The plaintiff and defendant agree that the plaintiff's Application for Mediation or Hearing is withdrawn. The defendant agrees to pay benefits on a voluntary basis in accordance with the following:

a. Weekly benefit rate $_____
Less benefits to be coordinated $_____
Subtotal $_____
Plus supplemental benefit $_____
TOTAL $_____
Benefits to be paid for the period from _____ through _____

b. Medical expenses to be paid? ☐ Yes ☐ No
If yes, to whom? _____

c. Reimbursement to group carrier? ☐ Yes ☐ No

d. Atty. fee to be charged Percent _____% Amount $_____
Atty. Fed. I.D.# _____

e. Amount of interest to be paid $_____

f. Additional agreements (attach additional sheets if necessary)

Neither the payment of compensation nor the accepting of same by the employee or his/her dependents shall be considered as a determination of the rights of the parties under this Act.

All benefits become due and payable on the day of personal service or the mailing date.

_____ Plaintiff

_____ Defendant

_____ Representative of Plaintiff

_____ Representative of Defendant

_____ Date

_____ Magistrate/Mediator

Authority: Workers' Disability Compensation Act 418.222; 418.223; 418.847; R408.33(2)(b)
Completion: Voluntary
Penalty: None

The Department of Labor & Economic Growth will not discriminate against any individual or group because of race, sex, religion, age, national origin, color, marital status, disability, or political beliefs. If you need assistance with reading, writing, hearing, etc., under the Americans with Disabilities Act, you may make your needs known to this agency.